Judicial-DHS Workgroup Minutes

October 6, 2011
10:00 am to 3:00 pm
Judicial Branch Building, Room 165
1111 East Court Avenue, Des Moines, IA

MINUTES

Attendance

Workgroup Members: Beth Baldwin, Dan Royer, Dave Bhasker Deb Littlejohn, Deb Schildroth, Diane Brecht, David Boyd, Gretchen Kraemer, Jerry Mays, Jesse Hornback, Director John Baldwin, Karalyn Kuhns, Kathy Butler, Kelly Yeggy, Kim Wilson, Linda Brundies, Mary Ann Gibson, Neil Fagan, Ron Berg, Steve Hoffman, Terry Rickers, Virgil Gooding

Legislative Representation: Representative Julian Garrett

Facilitator: Donna Richard-Langer, Iowa Department of Human Services

DHS Staff: Karen Hyatt

Other Attendees:

Annie Uetz	Polk County Health Services
Becky Smith	Terrace View Residential RCF
Betty Marxen	Taylor Ridge Estates, RCF
Beverly Zylstra	Department of Inspections and Appeals
Bill Freeland	House Democratic Caucus Staff
Brad Tron	House Republican Caucus Staff
Cathy Engel	Senate Democratic Caucus Staff
Chris Boyken	Duncan Heights RCF
Deanna Triplett	Iowa Behavioral Health Association
Deb Dixon	Department of Inspections and Appeals
Jessica Peckover	Johnson County Jail Alternatives
Johanna Pundt	Chatham Oaks RCF
Joshua Bronsink	Senate Republican Caucus Staff
Kelly Espeland	Iowa Medicaid Enterprise
Kelly Meyers	Iowa Health Care Association
Kris Bell	House Democratic Caucus Staff
Linda Hinton	ISAC

Mary Gross	Friendship Home Association
Marty Ryan	Justice Reform Consortium, Fawkes-Lee and Ryan
Rachele Hjelmaas	Legislative Service Agency, Legal Division
Ronda Bennett	Department of Inspections and Appeals
Susan Cameron	Iowa Center Assisted Living
Teresa Bomhoff	Mental Health Planning Council
Zeke Farley	House Democratic Staff

Agenda

- Introduction of members, guests, co-chairs and facilitator
- Review of first and second meeting and follow-up tasks
- Materials meeting minutes, documents, etc. on the website:
  - http://www.dhs.state.ia.us/Partners/MHDSRedesign.html
- Tasks: Recommendations for educating judicial magistrates and advocates on ways to enhance the consistency of services for individuals who are court ordered to a residential care facility. Address issues involved with identifying facilities with the capacity to provide an appropriate placement for an individual who had been arrested, charged or convicted of assault, a forcible felony, arson or an offence that requires registration as a sex offender under chapter 692A.
- Presentations by Diane Brecht, Penn Center and Kathy Butler, Partnership For Progress
- Group Discussion
- Initial Recommendations

Review of all Recommendations to Interim Committee

Review of meeting and follow-up tasks:

- Clarification was given regarding law enforcement training dollars and the limited time allotted for these trainings. When adding the recommendation to include mental health training for Peace Officers it is important to understand who falls under the Peace Officer category. Peace officers include: DNR Conservation Officers, City Officers of all ranks, Sheriffs and Deputies, State Troopers, IDOT Officers, Campus Police, Federal and State Agents from the FBI and DCI.
- Concern was expressed regarding the stigma of mental illness depicted in the training slides shared by the Law Enforcement Academy. The importance for educational and appropriate training was emphasized.
- A supportive comment was made regarding the importance of mental health literacy and an example was used describing the number of completed suicides of individuals who have been committed and released back into the community without proper support and services.
- Request by a workgroup member to include the name of who provides a public comment in this section of the minutes.

Task: Recommendations for educating judicial magistrates and advocates on ways to enhance the consistency of services for individuals who are court ordered to a residential care facility. Address issues involved with identifying facilities with the capacity to provide an appropriate placement for an individual who had been arrested, charged or convicted of assault, a forcible felony, arson or an offence that requires registration as a sex offender under chapter 692A.

Presentation #1 and Discussion
Diane Brecht, Penn Center and Kathy Butler, Partnership for Progress

- The traditional populations served in Residential Care Facilities (RCF) are individuals with chronic and persistent mental illness.
- Symptoms of chronic and persistent mental illness can be present between the age of one and eight years old and many symptoms are misdiagnosed; this can cause great complexity in adult years.
- Social histories of RCF individuals can be very complex and horrific regarding emotional, physical and sexual abuse.
- The current populations served in RCFs across Iowa include individuals with higher and more acute needs than when the RCF rules were first written. This is impacted by community support options not being available for people with acute needs.
- RCFs are treatment oriented in their mission and not meant to be facilities that house people without treatment goals.
- RCFs have the goal to move individuals back into the community at some point. At the Penn Center there are a few individuals who have lived there for 30 years, however, the majority are short term (one year or less).
- Some goals within RCFs are to stabilize individuals, teach living skills, and develop community based services especially in rural areas to ensure individuals have access to continued support once living independently.
- The court commitment process does have impact on the individual although it is recognized that at times commitment is necessary in order for an individual to receive the highest level of care.
- Individuals receive goal setting support while creating an individualized plan and learn what is necessary to have their commitment released. For the plan to be successful towards release, it needs to include viable solutions for housing, clothing and finance.
- At times, people are committed due to a lack of transportation and this type of committal is a high cost to the system and often one of the conditions where individuals seek to have their commitment released.
- There is not consistency in how RCFs are funded. The majority of RCFs are privately funded non-profits, some are for-profits and there is one in Story County that is county funded.
- RCFs determine their own admission criteria and protocols. This can make it difficult for the court system to choose a facility for a commitment. An application includes a physical report, TB status, funding information, and a social history.

- At times, RCFs can make an exception for an individual regarding placement and this is usually based on the information in the application along with a face-to-face interaction.
- At times, sheriff departments may bring an individual to a RCF without prior notice or application being in place.
- Penn Center does not accept people with a sex offender history and will not accept a referral without a face-to-face interview. Each RCF has specific criteria for admittance.
- RCFs teach individuals how to recognize their own symptoms and create a self-care plan.
- Phase out plans are created when a person is transitioning into the community.
- The lack of psychiatrists in Iowa is a hindrance and a complication for RCFs.
- If pre-screening becomes a *core service*, this would be helpful to find appropriate placement for people.
- If *centralization of case management services within regions* is part of mental health redesign, this would be helpful to RCFs.
- A system in place for real time bed queries would be helpful to RCFs, especially when people are court ordered and beds are not available. Communication between systems is necessary and it would be helpful to RCFs to have a tool to facilitate this.
- An example was given of work done in Dubuque, Waterloo and Cedar Rapids to educate law enforcement entities and magistrates on RCFs regarding admission criteria and policies. The drop off rate by law enforcement without prior notice is very low to rare in these counties post educational efforts.
- When an appeal is appropriate for an individual, the RCF staff, mental health advocate, physician, and individual work together on a decision to make this happen. A time when an appeal would not be appropriate would be when an individual is at risk of hurting self or others (emotional harm to others is often overlooked).
- Consistent rules across Iowa are necessary for appropriate placement when committals are court ordered into RCF placement.
- An individual in a RCF has the right to refuse treatment if not hurting another life. If a person leaves an RCF without a discharge plan in place, the RCF may be liable; therefore, an RCF may believe its recourse is to re-file a commitment.

- Percentage of individuals committed and living in RCFs:

Facility	Census	% Committed
Chatham Oaks, Inc	77	53
Country Care Center	35	40
PFP/Willow Heights	41	57
Prairie View	85	69
Penn Center	59	31

Discussion of Workgroup

- Lack of discharge planning from hospitals impacts the court commitment process.
- The majority of the time the magistrates will court order a commitment based on physician opinion.
- Agreement on the current severity of acute symptom seen in the RCF level of care. Historically a psychiatrist would be sent to do the review at a RCF (20 to 40 years ago). Current problems include complicated medical illness along with a mental illness diagnosis. The severity of this combination is much higher today.
- It was felt that commitment should be terminated when an individual is compliant with treatment.
- Concern was raised with the lack of consistency on how mental health advocates work with individuals. The importance of consistent mental health advocate training and education was stressed. It was also stressed that consistent mental health training needs to happen across the board for staff at the provider level, in hospitals, the court system, and law enforcement.
- It is also important for RCF staff to be educated on the role of the mental health advocate.
- A question was asked about the difference in data from the Governor's Developmental Disabilities Council December 2010 report regarding percent of voluntary and involuntary commitments than what was given in the presentation. In the referenced report, it was noted that the data is skewed because sub-acute ICFs data is included. There should be a differentiation between the RCF that are tied to an ICF and those that are free-standing.
- The majority of people go from psych bed placement into a RCF and some RCFs will not take individuals with chronic CMI diagnosis.
- Concern was expressed for the lack of consistency around admission criteria and the admitting decision.
- Compliance with regulations is a factor in an RCF accepting an admission. The waiting period to find a bed can raise the acuity level of the individual and symptoms can become exacerbated.
- Commitment is usually held by the RCF under the care of a psychiatrist and level of care designated. The providers are starting to see dual commitments.
- An informal network of RCF providers meet on a quarterly basis (20 to 30 participants) and the offer was made to have this group put together information for a database on RCFs that are known to consider placements out of the normal criteria, who will accept varying criteria and who will not accept outside of the current criteria. A recommendation was made to formalize this group.

Issues Facing RCFs

- Commitments happen for ease, transportation, funding and elder care and not just for dangerousness to self or others. (Currently the system is impacted by waiting list issues and funding complications.)
- An individual should not have to be committed to a nursing home when funding is lacking for other types of appropriate care. (Dependent self neglect cases are more appropriate for a guardian rather than a commitment; however, are hard to find if the services are not provided in the community.)

- Multi-disciplinary Education (including mental health, substance abuse) across a spectrum of positions, including magistrates, advocates, judges, and other critical positions within the court system is necessary. All education efforts should include consumers. Recommend all judicial officers have mental health and substance abuse training.
- Consistent forms should be utilized by the magistrate and court system. There is a pilot project working on the standardization of commitment forms for the periodic report form and the physician form. The forms are included in Chapter 12, page 16. The forms are for involuntary hospitalization for individuals who are mentally ill (4th Judicial District, Fremont, Mills counties) and in the 7th Judicial District (Davenport).
- The Iowa Code should be changed as the current code does permit placement without acceptance from the facility.
- A standard plan format would be helpful in order to have a commitment transferred to an inpatient facility from the RCF when necessary.
- Chapter 12 should be refined as it relates to new code language within 229.
- Important within new region structure to have an appointed position for coordination and communication.
- Case managers should ensure there is a uniform system in place to follow the progress of individuals who are transitioned into other care and support.
- A new level of care could be established with a specialized training for all staff involved.

Public Comment

Comment: The statement was made that comments made during the workgroup are appreciated and also appreciates being invited to attend the legislative workgroups. In the Governor's Developmental Disabilities Council report from December 2010 some of the recommendations are being worked on by DHS and DIA collectively. Continuum of Care is being worked on. There is agreement that acuity levels are higher across the continuum of service array and the determination of needs for individuals needs to be discussed. Wondering if the RCF is the right name anymore based on the current change in acuity levels being seen. What level of care can be provided where the needs are met and sometimes the needs are beyond the RCF level of care ability?

Comment: A representative for nursing homes indicated there is a Catch-22 for RCFs when a facility has the safety of care responsibility. Individuals with dementia who are unsafe are the responsibility of the facility and their job to keep people safe. When the facility is no longer able to guarantee this safety, other facility placement is sought. Involuntary discharge in these cases is very difficult. The representative recommends that involuntary discharge proceedings and regulations need reviewed regarding safety to assist in getting individuals the appropriate care.

Comment: Expression of concern made regarding level of care for an individual and medical order as it is felt that doctors are not educated on the function of the RCF or what level of care the varying facilities can offer. The definition of what is appropriate care is important. There are only two ICF-PMIs in Iowa and with chronic mental illness the RCF needs a certificate of need.

Comment: A representative from law enforcement and healthcare stated appreciation for the workgroup meetings. A comment was made that multi-disciplinary cross-training is critical.

Comment: A comment was made regarding jail diversion and the continuum of care as the challenge of the RCF is to admit individuals coming out of the correction system. Community based care needs to be available and funded for referral and placement. Expressed concern that in the adult workgroup RCFS are not part of core service recommendation and is confused on how changes will be made for RCFs.

Comment: Concern expressed about the different levels of acuity across the system and whether the facility is locked or unlocked. Importance of crisis stabilization services noted.

Comment: A RCF-PMI is not accessible for individuals unless the age is 65 or older due to funding and the cost is quoted at $475.00 per day (although this cost is variable).

Workgroup Discussion

- There have been pre-screening recommendations in earlier judicial workgroup meetings.
- Reminder that Director Palmer recommended a review by all the workgroups to make sure that all assigned tasks have been covered. Reviewed the reasons why RCFs were included in the workgroup and are at the table to answer questions about whether Iowa has the right facilities, number of beds and are people being housed appropriately.
- RCFs cover a wide range of service levels of care and acuities. Through the continuum of care there are a set of services from the mental health standpoint that would have a core set of services. Continued work on clarification of the workgroup recommendations is in the process including: facilities, populations and sub-acute needs.
- Clarification made regarding the non-acceptance of sex offenders in the Penn Center due to location and school district placement. Does assist with community integration work within the RCF. Arson and assault cases are reviewed for level of intent and decisions are made based on a person's individual history.
- There is a need to identify specialized services as all RCFs do not have nurses on staff to deal with significant medical problems.

- There are a number of people who cannot be placed for a variety of reasons (this is a small but growing pool of individuals) and this issue needs to be addressed as this issue is not going to decrease over time. There is a robust increase in individuals who are dependent on the system for care after being released from prison and individuals who are removed out of a RCF. There is a lack of a setting for people who need locked care outside the criminal system.
- There is a concern for veterans being sent to locked units that are established for dementia when the admitting diagnosis is not dementia related.
- There should be a new level of care and facility for the serving people whom no current facility or entity will accept.

Judicial-DHS Workgroup Initial Draft Recommendations

TRANSPORTATION RECOMMENDATIONS: (MEETING # 1)

1. Transportation for Court Committal process is a core service. This includes transportation to a CMHC or other designated facility for a mental health evaluation, to a hospital for admission and to a court hearing if the patient is attending.

2. Regions designate a transportation coordinator. The transportation coordinator where the patient is located/presents is to assign a sheriff or other appropriate transportation based on safety and the patient's best interest. Consideration should be given for actual costs to be paid as the current system does not reimburse at full cost.

PRE-COMMITMENT SCREENING IN COMMITTAL PROCESS RECOMMENDATIONS: (MEETING # 1)

1. Provide a provision in Chapter 229 that allows for pre-commitment services screening prior to the initial filing.

2. Pre-commitment services screening for involuntary commitments needs to be a core service.

3. The pre-commitment services screening would be the role of the CMHC or a designated facility contracted by the region.

INVOLUNTARY HOLD RECOMMENDATIONS: (MEETING # 2)

1. The recommendation from the workgroup is for a change in chapter 229.22 to allow for the 48-hour hold to be available 24 hours a day. This necessitates a change in section 602.6405 subsection 1concerning limitations on non-lawyer magistrates.

CHANGES IN CHAPTER 229 FOR MENTAL HEALTH PROFESSIONALS RECOMMENDATIONS: (MEETING # 2)

1. Remove from chapter 229 the title and definition of Qualified Mental Health Professional and any reference to it.

2. Support the provisions in chapter 229 that only a physician is to examine the patient and provide a report to the court from the initial hearing through the hospital discharge.

3. Support the provisions in chapter 229 that a psychiatric ARNP may provide periodic reports to the court for an outpatient committal.

JAIL DIVERSION RECOMMENDATION: (MEETING # 3)

1. Workgroup recommends jail diversion to be included as a core service. Suggested elements of such a system would be:
    - Intensive Case Management
    - Screening and Assessment
    - Training for law enforcement and Department of Corrections personnel similar to that provided in CIT or Mental Health First Aid.
    - Pre-Arrest: The goal prior to arrest is to keep the individual out of the system.
    - Single point of contact for pre-arrest, post-release and pre-release.
    - Definition: Level of assault needs to be defined for mental health criteria.
    - Discharge Planning: Assistance with housing, medicine and employment.
    - Sub-Acute level of care: 23-hour type of model that directs people to the right level of care.
    - Cost Avoidance: Must assist the population on the front end.

ROLE, SUPERVISION AND FUNDING OF MENTAL HEALTH ADVOCATE RECOMMENDATIONS: (MEETING # 4)

1. Review job description developed by the ad hoc mental health workgroup and implement state wide.

2. Supervision: The advocates need one single point of accountability that is independent and autonomous.

3. One entity oversees training, supervision, audits. The majority recommended that this not be the judicial system but rather a different system perhaps like the public defender's office or the casa structure.

4. The funding should be moved from the county to the state. Consistent reimbursement standards need to be developed.

COMPREHENSIVE TRAINING OF LAW ENFORCEMENT RECOMMENDATIONS: (MEETING # 4)

1. Strongly recommend that officers receive additional training in mental health each three year period which could include CIT and Mental Health First Aid.

2. Strongly recommend consumers are part of the officer training in mental health.

Adjourn

Next meeting is on October 20, 2011 at the Judicial Building.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.